Health Home Planning Workgroup
Meeting minutes for June 11, 2012 meeting
AmericInn, Fort Pierre, SD

Members in attendance: David Flicek, Dr. Tad Jacobs, Scott Graff, Rod Marchiando, Dr. Michael Farritor, Tony Tiefenthaler, Dave Hewett, Mary Weischedel, Terry Dosch, Colleen Winter, Barb Smith, Nicole Bartel, Amy Iversen-Pollreisz, Kim Malsam-Rysdon, Kathi Mueller, Representative Suzy Blake, Senator Corey Brown, Senator Jean Hunhoff, Representative Scott Munsterman, Senator Deb Peters and Lynette Huber

Others in attendance: Deb Fischer-Clemens, Cindy Morrison, and Jean Reed

Members Absent: Dana Darger, Representative Justin Cronin, Deleen Kougl and Sonja Weston

Meeting minutes:
The meeting began with a review of Health Home Workgroup purpose and scope of work that had been developed at the previous meeting (April 10, 2012). The purpose and scope reviewed is as follows:

- Analyze data and develop a health home based on the results of the data analysis.
- Measure and manage utilization to deliver cost savings and improved patient outcomes.
- Align the Health Home initiative with CMS' triple AIM.
- Become educated on Federal requirements of a Health Home and identify methodologies to expand participation.

At the conclusion of this discussion, an update on the Care Management Request for Information was requested. Kim Malsam-Rysdon provided the work group with an update and indicated that a separate meeting to discuss the proposal submitted by Sanford in response to the Request for Information was scheduled for later in June.

Eligible populations
Kathi Mueller provided the workgroup with an overview of populations served by other states where the State Plan Amendment has been approved. Six different states were reviewed and discussed. These included MO, NY, OR, RI, and NC. Kathi also discussed MN and indicated that although they had implemented patient centered medical homes, they have not yet tried to mesh their model into the Federal Health Home model. In each case the population was consistent with the definition in statute plus included various additional risk factors.

South Dakota Medicaid Health Home eligible population was reviewed and discussed. Specifically, the data review consisted of a review of the total Medicaid population (both medical and pharmacy) to determine the percent of population eligible to be enrolled in a Health Home. The specific data elements that were reviewed and discussed are attached to the minutes.

At the conclusion of this discussion, the group decided that the South Dakota Health Home population would include both individuals with two chronic conditions or one

chronic condition and at risk for another plus the SMI populations of adults. Risk factors identified by the group included smoking/tobacco use, cancer, chronic pain, hypertension, abnormal cholesterol, depression, substance abuse, and individuals who are taking multiple medications.

Provider Infrastructure

The group discussed who could provide Health Home services based on the Federal Health Home requirements. It was noted that states could adopt a mix of three types of provider models. These are as follows:

- Designated provider: may be physician, clinical group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other.
- Team of health professionals: may include physician, nurse care coordinator, nutritionist, social worker, can be free standing, virtual, hospital based, community mental health centers, etc.
- Health team: must include a medical specialist, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative medical practitioners and physician assistants.

Again, other approved state plans were reviewed and discussed. Several states adopted multiple models.

After some discussion, the group decided that the South Dakota Health Home provider infrastructure would be a designated provider. It was felt that this was necessary to establish accountability. Discussion around the designated provider team make-up identified additional roles that would be important to include in the model. A physician led designated provider team should also take into consideration a health coach/care coordinator, chiropractor, pharmacist, support staff, other community services, community mental health centers and others.

Provider Qualifications

As a follow-up to the last meeting, a review of the NCQA six must pass criteria was addressed in detail. It was noted, that again, other states have utilized NCQA accreditation as a means to address provider qualifications. It was stated that while many clinics across the state manage to the six must pass criteria, few if any are pursuing NCQA accreditation. The factors affecting this decision are both cost and a burdensome process. Some states have developed their own criteria. There is a reluctance to do this in South Dakota as it could result in additional expenses within DSS as current resources do not support individual/designated provider audits. The group discussed other market place quality initiatives they are participating in. It was suggested that a sub committee be established to review existing provider quality initiatives and what other states are doing to identify a solution for South Dakota. The subcommittee was established and will develop a recommendation to be presented to the entire group at its August 27 meeting.

In discussing provider qualifications, the providers at the meeting discussed how they are currently using data to support service delivery to people with chronic conditions. There was extensive discussion as to what data the state would be able to provide and how a provider would be able to see the entire scope of care a Health Home participant has accessed. The status of the Health Information Exchange was discussed and it was suggested that an update be provided at a future meeting.

Member Attribution
The group discussed how the eligible Health Home population would be assigned to the respective providers. It was agreed that the process needed to be State driven. The providers will provide a listing as to where they would consider doing pilots. The State will then identify qualifying patients and their respective primary care physician in those locations. The listing will be give to the providers for validation.

Core Services
For core services federal requirements include comprehensive case management, care coordination and health promotion, comprehensive transitional care, patient and family support, referrals to community and social support services. Again, other approved state plans and benchmarks from the Common Wealth Fund were referenced. It was recommended that a draft of core service definitions be developed and then presented to the group for review and acceptance.

Payment Subcommittee
It was recommended to the group that a payment methodology subcommittee be developed. The group agreed this would be a good idea. Subcommittee membership was discussed and again agreed that membership must be from the original group. The subcommittee will meet in person on June 27 and July 27. Their recommendation will be brought to the full group at its August 27 meeting.

Next meeting
The next meeting will be held August 27, 2012 from 10:00 am to 3:00 pm in Pierre. Location will be announced at a later date.